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ABSTRACT

This literature review focuses on social group work in the hospital setting. The first section addresses the need for a holistic approach within a typology of illness, and discusses the social work role and intervention tasks required at different stages of illness, i.e., diagnosis, adaptation to long-term illness, and the ending of the illness episode. A chart is provided for social group work intervention possibilities. Other sections address the following topics: Nature of the Illness-Defining Time Parameters, Group Format, and Goals; Chronic Illness; Social Nature of Chronic Illness; Value of the Group as a Support for Chronic Illness; Types of Groups in Hospital Settings; Social Group Work in a Medical Setting; Psychosocial Implications of Specific Physical Disorders, for Group Work in Hospitals. This last section deals with these specific disorders: cancer, home hemodialysis, hysterectomy, burn victims, epilepsy, neonatal intensive care, and newborn infant death. A reference list is included. (WAS)

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SOCIAL GROUP WORK IN HOSPITALS

by

Dr. Moses Stambler

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SOCIAL GROUP WORK IN HOSPITALS

There is a significant amount of group work taking place in hospitals, for patients to develop skills and competencies to cope with psychosocial problems resulting from physical disabilities. Although the host institution is a medical one, the group approaches are not in the "medical clinical" categorization, but rather group counseling and guidance.

In the numerous papers read for this report, no clear framework for group work practice emerges. There is primarily a description of the problems, and of groups established to assist in coping with the medical problems. There is not however a systematic analysis of social group techniques used with the groups. I suspect that this results from the case work background of social workers in hospitals. In a hospital setting, it is a person with case-work rather than group work training who would be considered for employment, and I have noted few if any social workers in hospital settings have from the group work discipline. Most are case-workers applying rational approaches in their work with groups, and basing these on psychosocial knowledge and medical understandings. This study has made me feel that hospital based social workers could probably utilize to advantage some basic skill background in social group work.

A. NEED FOR A HOLISTIC APPROACH WITHIN A TYPOLOGY OF ILLNESS

Severe illness of an individual should be dealt with as a bio-psychosocial entity. There are physical intervention needs required by medical authorities and those assisting them, and there are psycho-social factors that should be dealt with as well. Once an illness has taken hold, it should be approached from an ecosystems approach, and result in needed social worker intervention, and social group work practices where appropriate. Four major variables in the ecosystem impacting the psychosocial coping capability of the ill person are: The individual himself, the family, the health care system, and friendship - support groups. Their role at different stages of the illness can be particularly important in post-hospital functioning and adaptation of the patient. The group worker should consider intervention and group support in as many as these areas determined by the situation.

A typology of illness is helpful as a way of defining the different interventive tasks required at different stages of the illness with any of the above four significant parts of the ecosystem. The first stage the Diagnostic phase occurs at the onset of illness and is the one in which adaptation must be made. In this stage the individual and family deal with a period of uncertainty during which the patient's symptoms have been noted but without a definitive diagnosis. This period includes anxiety about not

knowing, fears and fantasies of what is wrong and possibly guilt feelings for what might be happening. Often this diagnostic period lasts a long time, and can pose great stresses on the individual and his family. Three types of adaptive behavior can be important at this first stage. The securing of the right amount of information to guide action (neither a flooding nor inadequate information to allow the person to make reasonable choices), maintaining internal balance and organization. This would require blame, guilt and shame and loss to be dealt with by appropriate organization of the relationships and family support system and preserving enough autonomy in the person who is ill.

What should be the role of the social worker during the crisis of the diagnostic stage. His role is critical during this stage. (Mailick, 123)

> In times of stress individuals and families are more open to intervention, so the opportunity exists to help initiate or encourage an adaptive process. The social worker should be ready to provide services that will support the patient and the family's social functioning without taking away their autonomy. During the diagnostic period the patient and the family may require help in meeting emotional and material needs.

The second stage of illness, after the first one, the diagnostic stage, is one of actual adaptation to long-term illness. Patient tasks include (Mailick, 123-24):

> ... adapting to ongoing discomfort, pain, and loss of physical control as well as changes in physical

> appearance. The family on its part must deal with its feelings in tolerating the patient's suffering and anguish, its sense of powerlessness (especially difficult for parents to bear), and its ambivalence, anger and guilt, as well as its fear for the patient and for themselves.

Additional needed patient skills include (Mailick, 123-24):

> ... learning how to interact and respond to physicians and other health personnel. He or she must learn how to take as active a role as possible in planning for his or her own care, find a way to be active in his or her own care, and deal with the attitudes and behavior of health workers. Especially difficult for the patient is finding an appropriate way to be assertive and even to express anger without endangering the relationships with physicians and other health personnel.

Another task is the management of role shifts. The temporary assumption of the sick role (Parsons) now becomes a permanent change and requires changes in self-conception, body image, personal aspirations and a host of family role relationships. The social work task during this period is to work intensively with the patient and the family to help them accept the reality of ongoing illness. A number of problem areas of particular importance for the patient might be, exaccerbation of age specific conflicts, "...self-image, sexuality, identity, peer relationships, work roles, autonomy, and authority." (Mailick, p. 124)

During this period, it is important for the social worker to take an active role in the collaborative process of the health team, and monitor the health team to help insure that patients adapt productively. Health care workers need to understand the importance of the quality of their interaction with the patient and family, and the symbolic importance of the health authority for improving patient adaptability (Mailick, p. 125).

The third stage is the ending of the episode of illness, which could result from care, remission or terminality. If the culmination will be one of terminality, the social worker can help work through the stages of death and dying for the patient and family members. If the patient goes into remission, the social worker must help family and patient alter their expectations, role assignments, health procedures and the tensions between patient and family that follow the long-term illness period, and learn to cope with the tensions of a remissions "twilight zone". (Mailick, 128)

The role of the social worker is relevant at each of these three stages both in terms of facilitating the coping and adjustment of patient and family, and that of the medical staff, so that what emerges are mutually supportive relationships.

SCHEME FOR SOCIAL GROUP WORK INTERVENTION POSSIBILITIES

STAGES OF INTERVENTION

LEVELS OF INTERVENTION	DIAGNOSTIC STAGE - stress, uncertainty, guilt feelings, fears, fantasies NEEDS FOR ADAPTIVE BEHAVIOR: 1. Adequate information 2. Internal balance 3. Autonomy of patient 4. Blame, guilt and shame to be dealt with by appropriate organization	ADAPTATION TO ILLNESS STAGE - Nature of illness defines time parameters, group format and goals. - Acute (temporary) Regression to sick role can be positive - Chronic (permanent) - regression is maladaptive NEEDS FOR ADAPTIVE BEHAVIOR BY PATIENT AND FAMILY TO: 1. Pain, discomfort, loss of physical control, physical appearance, suffering, anguish, powerlessness 2. Interaction with health personnel and expressing feelings without endangerment 3. Role shifts possibly requiring change in self-conception, body image, personal aspiration, and family relationship
1. INDIVIDUAL		
2. FAMILY		
3. HEALTH CARE SYSTEM		
4. SUPPORT GROUPS		

C. NATURE OF THE ILLNESS-DEFINING THE TIME PARAMETERS AND GROUP FORMAT AND GOALS

The nature of an illness helps define the time frame for group involvement, the needs for required supportive services, the tone and direction of group dynamics, and the appropriate format. Short-term illnesses such as the danger of crib death result in highly stressful situations, with psychosocial ramifications, within a clearly limited time frame. Once the baby is past that danger stage, there is no longer need for group activities, and the situation can return to a more normal level. A longer time and more interactive adjustment might be required for burn units groups, but here too with the eventual use of plastic surgery and skin grafts, the physical scars might be reduced or eliminated. With long term situations such as dyalisis, a permanent situation of being "hooked" up to the lifesaving machine prevails and group activities and functions although most intense in the initial phases, might well be useful at different life stages. Epilepsy too can use group work intervention more intensively at the beginning, and less intensively at different life stages.

The cancer group is one that poses another type of situation with more existentialquestions being raised and the immanence of death remaining a constant factor in a person's life. The group might well remain as permanent group to cope with this potentially terminal illness. It is the social group worker task to design intervention at the appropriate level.

D. CHRONIC ILLNESS

Chronic illness requires a different role and status of the patient, consequently a different type of social worker intervention (Parry, 59-60).

> While regression is sometimes helpful in acute illness, it becomes maladaptive in chronic illness. The secondary gains achieved by giving up adult responsibilities become very tempting to the chronically ill person. Interventions into these regressive patterns can significantly effect the eventual integration of the disabled into the community. Group work services offer a method of intervention that is productive from the time that acute illness subsides until the patient is able to maintain the optimum health within the constraints of his disability.

Inviting out-patients into the group of chronically ill, results in. "... interaction of the in- and out-patients becoming a powerful asset for physical therapists, speech therapists, nurses, and physicians in facilitating rehabilitation." (Parry, 61)

Chronically ill and disabled people (Parry, 62)

> ... are most vulnerable to the demands of change including its pain... The chronically disabled individual has to cope with much more than a handicap or a disease process.
>
> Chronic illness is marked by an indeterminateness of closure in the disease process; the undocumented nature of costs attendant to disease reduction or elimination; weak health system ties among organizations serving this group; the interchangeability of treatment sites and personnel; a strong interplay of medical, social, and economic factors; and a pronounced neglect by health personnel.
>
> Chronic illness often results in severe limitations of activity and mobility. This means the inability to carry on the usual activity for one's age-sex group, such as working, keeping house, going to school, rearing children, being restricted in the amount and kind of usual activity, or experiencing restriction in relation to other activities.

The social group worker should consider the above psychosocial characteristics of chronic illness in designing group work intervention with the individual, family, health care system, and/or support groups.

E. SOCIAL NATURE OF CHRONIC ILLNESS

Chronic illness has a significant impact on the social relationships and settings of the patient. Bracht notes (Bracht, 139)

> The needs of the chronically ill and their families are frequently quite complicated and their total adjustment to life may be altered. Suchman found that one out of five patients reported that their current diagnosis called for changes in eating, drinking, or smoking. In addition:
>
> - 50% were concerned about carrying on normal activities;
> - 22% about loss of independence;
> - 37% about the cost of treatment;
> - 30% the loss of work; and
> - 15% concerned about the interruption of personal plans.

He also notes the significant impact that disability has on family social relationships (Bracht, 140).

> "... more marriages among the disabled end in divorce than among the non-disabled. (Franklin states):
>
> The educational , geographic and economic resources available to ... families... of the severely disabled, were less abundant than for the general population. The extended family generally provided no greater support to the disabled than to the healthy population. So the nuclear family was forced to cope with its problems as well as it could. Men and women withdrew at a slower rate from their sex-assigned roles. Decreased participation in most aspects of living highlighted the patterns of the disabled in their family settings. Chronic poor health improverished not only those it afflicted but also those living with them.

Because of their nature, persons with chronic diseases, can utilize groups as effective support agencies (Parry, 63)

> Chronic diseases tend to result from multiple causes, some of which are tissue breakdown, trauma, residual effect of acute illness, and unhealthy living patterns.... the search for the cause may be a hopeless pursuit because most disease states are the indirect outcome of circumstances rather than the direct result of single determinant factors. The group work method accepts the multiplicity of casuality and is helpful in containing illness along social and economic indices. If the group can help the individual to cope with a particular stress of illness, there is the possibility for resolving the problem in the community rather than the hospital. Woven into the very fabric of the concept of rehabilitation is the goal of return to the community. work can serve as the linkage for the disabled patients between the hospital/medical systems and the social/ community systems.

F. VALUE OF THE GROUP AS A SUPPORT FOR CHRONIC ILLNESS

The group can be of particular value as a support group for coping with chronic illness (Parry, 62-4)

> Getting together with other people who have similar problems offers informal supports that enable individuals to look at their specific problems more easily. The group offers the opportunity to explore in a non-threatening environment the impact of their health condition on members' lives. Group members realize, perhaps for the first time, that they are not alone with their problems, that other members cope with the same problem that was perceived as unresolvable. Another phenomenon that occurs in such a group is the mobilization of group effort on behalf of a particular patient who is undergoing stress. This, in turn, alerts the social worker, nurse, or other member of the health team to the specific need, and professional input is then lent to the person in need...
>
> The stigma attached to disability whether visible or not has a major impact on individuals who return to their families... the physically disabled often feel shame and disgrace, while the physically normal feel discomfort being with the physically disabled and often reject and withdraw from encounters with them. These kinds of problems are more easily dealt with in the accepting atmosphere of a group where the commonality of experience allows the participants to examine the full ramifications of their disability.
>
> One of the major benefits such a group for chronically disabled can open to its members, is allowing them to come to grips with their feelings, thoughts, fears, and fantasies about death... in a group there is the chance for people to discover that they are not so "odd" or different as they think, and the commonality of the experience is a way of univeralizing it. One of the major purposes of such a group is to help the members feel as normal as possible within the constraints of the chronic condition or disability.

In physical chronic disability, there is much dependency created... the forced dependent position of a patient's illness may make it impossible for him to again be independent, and the regressive, dependent trends become overwhelming. The group focus on peer support and encouragement of concern for each other helps to break down the excessive dependency needs. When a group member can help another member, he is performing an independent action. It is the combination of feeling needed and the need to receive feedback feelings from others that is important in this kind of group.

A significant phenomenon that often occurs among the chronically ill is non-adherence to a medical regimen. This non-adherence can take various forms - from the diabetic who refuses to follow the diet to the emphysema patient who rejects breath-giving machinery. Non-adherence can be caused by denial, anger, a cry for help, or a last attempt to withdraw from a painful and seemingly endless situation. In the group, the medical or technical information can be provided by the physical therapist, occupational therapist, speech therapist, respiratory therapist, nurse, or physician, in conjunction with the social worker and reinforced by group members. One of the major challenges for any member of the health team is to encourage the patient to learn self-care and demonstrate that disability does not have to be dysfunctional. Self-care taught within the nurturing atmosphere of group members with very similar problems is greatly facilitated.

G. TYPES OF GROUPS IN HOSPITAL SETTINGS

Alissi notes the generalized nature of group work in the medical and clinical setting, and although he refers primarily to psychotherapy, his views reflect characteristics of psychosocial supports for biological disabilities as well. He notes, (Alissi, 343)

> The group procedures that have characterized the medical-clinical field, in contrast to the usual accepted standards of the profession, have lacked specificity and standardization. No classification has as yet been developed that clearly explicates group methods and techniques in dealing with and "curing" medically recognized problems and symptom categories. Whereas a range of practitioners with varying kinds of training engage in group treatment in medical settings, it would appear that it is more often the conceptualizations and terminologies that are carefully guarded rather than the actual practice techniques...

In a hospital setting, group work stresses counseling and guidance and focuses on remedial approaches (Alissi, p. ?)

> Alternately referred to as "rehabilitative" or "treatment" models, remedial approaches focus primarily on helping individuals cope with problems of psychological, social, and cultural adjustment. They are based largely on the medical or clinical approaches where the emphasis is placed on study, diagnosing, and treating clients who are experiencing problems of adjustment in their personal and social relationships. The individual is viewed as the primary target for change, which is accomplished through carefully selected group experiences. The worker is seen as a change agent who is responsible for guiding the group

> through treatment stages that take place in and through the group. The group is both the means and the context for change. In this model, the agency is perceived clearly as a treatment setting in which groups are formed to treat individuals in accordance with specific treatment objectives.

In the numerous groups that function within the hospital setting, this counseling guidance categorization fits most effectively, with a dominant "problem solving approach." In this method, discussion is a key feature of problem solving, with some focusing on learning specific technical skills, regarding this Kinnick method, Alissi notes (Alissi, 355),

> The primary purpose is to help the student learn the necessary skills to improve his ability to solve his own problems through experience in group deliberations. The method is used with normal but 'troubled' individuals.

H. SOCIAL GROUP WORK IN A MEDICAL SETTING

The role of social workers in hospitals revolves primarily around their job of discharge planning, of linking a discharged patient to community resources that will facilitate rehabilitation and needed support services. In many ways, social workers resent this almost exclusive focusing on discharge planning to the detriment of providing other social services in hospitals. However, for the hospital administration, this is an important economic role. Medicare funds for illness are prescribed within time constraints for illness and the condition of the patient. If the patient is no longer in need of a hospital bed, administrators in the hospital become very concerned with medicare reimbursement and other cost factors, and generally want the patient discharged. The discharge planning job done by the social worker enables them hospitals to maintain a flow of patient in the context of economic efficiency, or inefficiency, whichever is preferred.

Unfortunately, a social worker role in most hospitals is limited to limited services and discharge plans. However their role for the patient should encompass a much broader scale, and they should be more involved in case management and group work. This expanded role would be advantageous to the patient and would enable effective social group work by medical social workers, knowledgeable about psychosocial needs

To secure information on what is being done and how it is being done, the author has attended a number of group sessions in hospitals, and has reviewed the literature of actual social group work sessions with chronic physical illness in hospitals. The author has not dealt with the area of hospital psychiatric services, a major area in its own right.

In comparing and summarizing actual cases in hospital social group work, the author has had to deal with the ecclectic rather than a clear social group work discipline. The approach seems to be uneven in hospitals where social workers are primarily guests of a host agency, and hired for their case work background rather than group work competencies. Social workers in hospitals, may become involved in group formation, organization, counseling and guidance but are generally not prepared to work with groups and have been trained in other social work methods. Their summary reports on groups do not have parallel analytical categories and concepts. In addition, not all the groups operational

in hospitals are conducted by social workers. Nurses and non-medical personnel have been involved in group operations, their reports included here are therefore somewhat difficult to deal with comparatively; there are many information gaps on processes and group dynamics.

In a hospital setting, and outside as well, the nature of the setting and illness provide parameters and constraints on group work decisions. Guided by these constraints, group workers must select their strategies.

POLARITY CONDITIONS FOR SOCIAL GROUP WORK IN HOSPITAL SETTINGS
(Based on concepts delineated by Kerson)

A. POLICY FORMULATION/ORGANIZATION

/ Private practice	V.A. /

B. TECHNOLOGICAL SOPHISTICATION

/ Non-medical apparatus settings	Burn unit and Renal dialysis

C. WHO DEFINES THE CLIENT

/ The Social Worker	The hospital agency	The / funding body (American Cancer Socie

D. DEFINING THE GROUP

/ Members Define Group	Given Definition/ by Situation in the Hospital

E. GOALS

/ Medical Information (e.g. burn unit)	Social (e.g. emphysema, halfway house)	Psychological (e.g. mental health)	Philosophical and / Existential (cancer terminal patients)

F. SETTING/DEFINING GOALS

/ Client sets goals (e.g. quadrapalegic)	/ Social worker sets goals (e.g. Substance abuse)	/ Medical goals (e.g. tertiary care)

G. CONTRACT

/ No contract One day at a time	/ Individually drawn contract (e.g. Treatment plan at halfway house)	Social worker- / agency contract	Clearly / drawn contract

H. TIME PERIOD

/ Short contacts	/ Forever (e.g. Leukemia, dialysis)

I. ROLE OF SOCIAL WORKER

/ Education & support	Intermediary between patient / family, and medical system

J. EDUCATIONAL EMPHASIS

/ Alternate Learning Approaches (manuals, A/V, Readings)	Didactic /

K. Source: Kerson, Toba, Social Work in Health Settings, New York, Longmans, 1982

I. PSYCHOSOCIAL IMPLICATIONS OF SPECIFIC PHYSICAL DISORDERS, FOR GROUP WORK IN HOSPITALS

1. CANCER

Some groups have been formed for parents of children with cancer. (Rudolph, et. al., p. 43-44)

> Parents of children with cancer experience many psychological and social stresses. They may have difficulty communicating with one another, marital problems may develop, and parents may become severely anxious or depressed. Concerns about the emotional well-being of the child with cancer and of siblings may appear. Questions about the disease, discipline, school, nutrition, and treatment procedures are common. Finances, transportation, and obtaining temporary housing near the treatment center may be burdens for many families, particularly those living far from the treatment center.
>
> Since over one-half of children with cancer survive for long periods of time, it has become more difficult for staff to meet these needs on a one-to-one basis. One alternative has been the use of groups to help parents of children with cancer deal with these problems. These groups are often led by a social worker or a nurse, occasionally with the assistance of a physician, and provide an outlet for personal sharing of experiences and for mutual support. Some have had informal discussions for information exchange, while others plan episodic educational sessions.

2. HOME HEMODIALYSIS

In dialysis, there are clear psychosocial implications and group work advantages. (Roy, Flynn and Atcherson, 65-66)

> People who are facing similar complex and stressful problems can offer a special kind of empathy to each

other. This empathy is nowhere more evident than in a home dialysis training unit among spouses or other relatives being trained to help a patient to dialyze at home.

... spouses or relatives studying home dialysis with patients share many of the stresses of renal disease. Such stresses include the pervasive fear that the patient might die, the possible impact of the patient's illness on the family's life-style, significant changes in the relationship with a sick spouse, and lost personal opportunities for career advancement, recreation, or travel. In addition, even though the health care team deemphasizes speed of mastery of home dialysis procedures, the assistant often feels particular pressure, as the well member of the dialysis couple, to train as quickly as possible so the couple can return to their home community and usual family life. These stresses add to the difficulty of learning to perform home dialysis with the renal patient.

To help home dialysis assistants deal with such stresses, the health care team decided to offer them weekly group meetings.

3. HYSTERECTOMY

There are also clear psychosocial problems that can develop with hysterectomy, and positive group work intervention potential (Keith, 59-63)

For the hundreds of thousands of American women who undergo a hysterectomy (surgical removal of the uterus) each year, infirmity and physical suffering may be eliminated, but mental and social well-being may be

dangerously undermined. A hysterectomy produces uncertainty, anxiety, and threats to fundamental feelings of femininity and sexuality. It is currently the second most common type of major operation in the United States, and of all major and minor surgeries, it ranks fourth. Arguments rate in the medical community, as well as in women's groups, regarding the necessity for performing so many hysterectomies. Even when the operation is necessary and the patient herself is convinced of its necessity, the woman's concerns remain and may seriously affect her physical and emotional functioning.

... "hysterectomies are more liable to be followed by psychosis than other gynecological procedures" and ... psychiatric admissions vary from "somewhat" to "strikingly" higher after the performance of gynecological surgery.

Although most women who undergo a hysterectomy do not experience subsequent psychiatric hospitalization, "about 40 percent of gynecological operations are followed by some degree of depression," lasting for months in some instances. Anxiety, lessening of sexual desire or functioning, and compulsive overeating often occur as a result of a hysterectomy. The prevalence of old wives tales in all sectors of society concerning this operation contributes to the apprehension among these women. For example some women believe that after a hysterectomy woman will become fat, grow hair on her face, lose her sexual desire and desirability suffer from mental disorder.

4. BURN VICTIMS

There is also apsychosocial need for social reentry and rehabilitation services by burn victims (Cahners, 165):

> ... people who are victims of severe burns suffer not only fromthe physical pain, but also from long-term emotional scars. Adult burn victims see themselves in the mirror, know they have changed, and may seek help in adjusting. Children, on the other hand, do not depend on mirrors. They see themselves as they are reflected in other people's eyes, and they feel the shock of social rejection bit by bit as they grow up and encounter new people and new experiences. During the time they are growing up, they need to be nurtured, protected, and influenced by a family - their natural family, a foster family, or distant relatives. If this family is emotionally healthy, the child may also become emotionally healthy, in spite of any handicaps, as she or he matures to adulthood. If not, the result could be psychological devastation. Therefore, in addition to monitoring, understanding, and treating a burned child's emotional reactions to social reentry and rehabilitation, it is also important for hospital workers to do the same for the parents of children who have suffered a burn trauma.

> Many parents of infants in newborn intensive care units (NBICU's) go through identifiable stages of emotional reactions... The initial response is usually overwhelming shock, characterized by irrational behavior, crying, feelings of shock, many try to escape the situation with denial: "It can't be happening to me." Following the stage of denial are intense feelings of sadness and anger. Anger may be directed toward themselves, the baby, members of the medical team or God. Parents will be anxious and worried about the baby's chances for survival. Some may be hesitant to become attached to the baby, fearful that the baby will die. The fourth stage is characterized by adaptation, a lessening of the intense emotional reactions and increased ability to begin caring for their infant emotionally and physically. During the final stage, reorganization, parents deal with the issue of responsibility, and are hopefully able to acknowledge that the infant's problems are not their fault. This process may take a few days to several months; in some cases it may never successfully resolve.

6. EPILEPSY

Epilepsy too requires psychosocial support of social work intervention (Appalone, 23-4).

> Epilepsy is a medical disorder with social and emotional ramifications that may be more disabling to the patient than the physical aspects... Like other chronic illnesses that may be acquired in childhood, epilepsy often results in parental attitudes of overprotection and infantilization. Such treatment can cripple the child emotionally in ways that foster feelings of inadequacy, helplessness, and dependence. Although the seizure disorder may be well controlled or even resolved by adulthood, the young adult may have assumed the role of the sick person for life. This role continues to be reinforced by the

5. NEONATAL INTENSIVE CARE

The neonatal group is in need of psychosocial intervention (Mahan, p. 67-68).

> Our culture views the birth of a baby as an exciting, happy event, surrounded by much preparation. There is preparation of the nursery and purchase of baby supplies as well as emotional anticipation. Parents spend a good deal of time imagining what their baby will be like, anticipating the joys of growth and development. The birth of a sick newborn, therefore, throws the family into a crisis for which they are unprepared. Early interventions is essential in order to work towards a positive resolution of the crisis. ... social worker ... interventions... may assist the family at this vulnerable time...
>
> When told that their infant is sick, parents are confronted with numerous issues. Not only is there mourning for the loss of the perfect child that was expected, but there is also anticipatory grieving for the baby whose life is now in jeopardy (Olshansky, 1963). Only after recognizing their loss can parents begin to form a relationship and an attachment with their baby. Mothers may feel a sense of failure because they were unable to carry a pregnancy to term to produce a normal, healthy infant. All parents search for a reason why this happened to them. There may be considerable guilt as parents wonder whether their actions or thoughts caused the baby's problems. Many mothers have felt ambivalence at some point in the pregnancy and may now feel that the baby's illness is punishment for those emotions. Parents often find irrational reasons for the illness - for example, the one day prenatal vitamins were forgotten, exercising too vigorously or not exercising enough. Parents will likely benefit by verbalizing these feelings both between themselves and with hospital staff. It is helpful to inform them that most parents of sick newborns have similar feelings.

Mahan suggests a stage theory for parents in the neonatal group. Understanding of these stages can provide a social group worker with more pinpointed intervention strategies (Mahan, 67-68)

family that is frozen into a dysfunctional pattern of interaction. These young patients express frustration with their social situation, complaining their families smother them with limitations. However, individual casework with these individuals is frequently frustrating because resistance to relinquishing the sick role proves overwhelming.

Group work is an alternative treatment modality that is successful for many. For the past 2 years these authors have led short-term groups with young adult patients who have epilepsy. This paper discusses the group process and the issues involved in group work with this population. Much of this discussion may pertain to other young adults with a history of physical problems who are locked inappropriately into the sick role... people may have difficulty functioning in various roles because they do not know what is expected. Many of these persons are so locked into the sick role that access to other roles has been denied. Accordingly to Klein, a person can be taught about roles: an important task of groups is such re-education. The group functions as a microcosm of society offering these patients experiences unavailable to them elsewhere. It provides an opportunity to practice behaviors, learn skills, gain insights, and build confidence necessary for the eventual assumption of different life roles.

7. NEWBORN INFANT DEATH

Despite the advances in neonatal and pediatric medicine, young infants still die as a result of major birth defects or severe illness. Their baby's death may be the greatest tragedy the parents feel they have ever experienced.

Grief Reactions of Parents

Parents who experience a neonatal death, whether the baby lived one hour or for a much longer period of time and whether or not they saw or touched the baby, go through an identifiable grief and mourning experience. There are developmental stages of complex emotional responses parents experience during the initial stages of the infant's illness. (Rappaport, 57-58)

> These early responses, the grieving over the loss of the hoped-for healthy baby, the despair and depression, the denial and fear, the questioning and searching for the causes, the threat to the parents' sense of adequacy and self-esteem, the guilt and doubt, the difficulties of bonding emotionally with the "defective" baby, will already be present at the time the parents learn that the baby may not or will not survive, throwing them even deeper into a state of crisis and disequilibrium...
>
> Following the death of an infant, parents experience both identifiable grief (the intense feelings of emotional suffering following a loss) and mourning reactions... Following the death the parents may experience somatic complaints, e.g., shortness of breath, faintness, inability to eat or sleep, and overwhelming feelings of sadness and loneliness. They may find themselves crying every day for several weeks or more, or may actually be distressed that they cannot seem to "let go" and cry. They may be preoccupied with the image of the baby trying to remember exactly what he/she looked like, or having pictures taken of the child inside the coffin, which they show repeatedly to people following the funeral.

CONCLUSION - In this preliminary study, I have attempted to show some comparative dimensions of social group work in the hospital setting. The different ailments suggest need for different group work intervention. There are 4 types of people who may be formed into homogenous groupings are heterogeneous groupings with others. These people are patients, family, health care professionals and like interest support groups. In future papers, I plan to develop the intervention strategies in greater detail.

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